Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

State of Florida

1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. __X__ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 24 of the Medicaid State Plan.

B. __X__ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. __X__ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

Only children under 21 years of age, enrolled in the Developmental Disabilities waiver(s) will be self-directing their State Plan personal care services.

B. __X__ Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

Service providers will be enrolled with each authorized state agency Fiscal Employer Agent (FEA) designated on behalf of the Consumer Directed Care Plus (CDC+) program. Providers must attest to the provision of services in order to receive payment for services. All providers must be at least 16 years of age and must satisfy the qualifications, requirements and applicable licensure for the service that is provided. Providers must also comply with the background screening requirements and provisions of the applicable Florida Statutes.

Aged/Disabled Adult (A/DA) Services Waiver: Homemaker, Personal Care, Respite – Facility Based, Respite In-HomeAdult Day Health, Home Accessibility Adaptation

- Skilled Nursing
- Specialized Medical Equipment and Supplies
- Chore
- Chore - Enhanced
- Personal Emergency Response Systems (PERS) - Installation
- Personal Emergency Response Systems (PERS) - Maintenance
- Adult Companion Services
- Caregiver Training and Support – Individual
- Caregiver Training and Support – Group
- Attendant Care Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Home Delivered Meals
- Financial Risk Reduction – Assessment
- Financial Risk Reduction – Maintenance
- Nutritional Risk Reduction
- Physical Risk Reduction
- Counseling
- Escort
- Consumable Medical Supplies - Enhanced
- Pest Control – Initial Visit
- Pest Control – Maintenance
- Rehabilitation Engineering Evaluation
- Respiratory Therapy
- Consumable Medical Supplies

Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) Waiver

- Personal Care Services
- Adaptive Health and Wellness
- Assistive Technology
- Attendant Care
- Behavioral Programming
- Companion Care
- Consumable Medical Supplies
- Environmental Accessibility Adaptations

Life Skills Training, Personal Adjustment Counseling, Rehabilitation Engineering Evaluation,

Developmental Disabilities (DD Tiers 1, 2, and 3) Waiver: Personal Care, Residential Habilitation, Supported Employment, Respite, Environmental Accessibility Adaptations, Personal Emergency Response Systems, Companion Services, Behavior Analysis Services, Behavior Assistant Services, Adult Day Training, Dietician Services, In-Home Support Services, , Special Medical Home Care, Support Living Coaching, Physical Therapy Services, Occupational Therapy Services, Speech Therapy Services, Durable Medical Equipment and Supplies, Private Duty Nursing, Specialized Mental Health Services, Transportation, Adult Dental Service, Respiratory Therapy, Skilled Nursing,

Family and Supported Living Waiver (DD Tier 4): Adult Day Training, Respite, Supported Employment, Transportation, Behavior Analysis Services, Behavior Assistant Services, Environmental Accessibility Adaptations, In-Home Support Services, Personal Emergency Response System, Specialized Medical Equipment and Supplies, and Supported Living Coaching.

Individual Budgeting (iBudget) Waiver: Life Skills Development, Adult Dental Services, Behavior Analysis Services, Behavior Assistant Services, Personal Supports, Specialized Medical Equipment and Supplies, Dietitian Services, Environmental Accessibility Adaptations, Private Duty Nursing, Occupational Therapy, Personal Emergency Response System, Physical Therapy, Residential Habilitation, Respiratory Therapy, Respite, Skilled Nursing, Special Medical Home Care, Specialized Mental Health Counseling, Speech Therapy, Supported Living Coaching, Transportation, Family and Guardian Training, and Person-Centered Planning.

iii. Payment Methodology

A. __X___The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services. The State uses the same payment methodology for individuals self-directing their State plan personal care services.

B. __X___The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan

personal care services or for section 1915(c) Home and Community-Based waiver services. Amended Attachment 4.19-B page(s) are attached. The State uses a different payment methodology for individuals self-directing their section 1915(c) Home and Community-Based waiver services.

iv. Use of Cash

A. _____ The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. __X__ The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

A program consumer may elect to discontinue participation in the Consumer-Directed Care Plus (CDC+) program at any time.

In the event disenrollment is requested, the consumer's consultant completes a CDC+ Change Form to disenroll the consumer and forwards the form to program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form.

Program staff notifies the Agency for Health Care Administration about all disenrollments . Upon disenrollment from CDC+ the consumer may access waiver services through traditional means.

The consumer's consultant is responsible for ensuring the consumer has traditional waiver services in place to begin the first day of the month. Therefore, there will be no lapse in services.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below. Consumers may be disenrolled by consultants and CDC+ program directors.

Reasons for involuntary disenrollment include:

- Consumer moved out of state;
- Temporary or permanent long-term care facility admission;
- Hospitalization for more than 30 consecutive days;
- Loss of Medicaid eligibility;
- Loss of waiver eligibility;
- Representative not available if necessary for participation;
- Death of consumer;
- Mismanagement of budget;
- Consumer health or safety at risk;
- Consumer can no longer be served safely in the community.
- Admission to a licensed facility (group home, ALF, etc.)

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

In the event disenrollment is required, the consumer's consultant completes a Consumer-Directed Care Plus (CDC+) Change Form to disenroll the consumer and forwards the form to program staff. All disenrollments are effective the first day of the month following receipt of the disenrollment form.

Program staff notifies the Agency for Health Care Administration about all disenrollment. Upon disenrollment from CDC+ the consumer may access waiver services through traditional means.

The consultant is responsible for ensuring the consumer has traditional waiver services in place to begin effective the first day of the month. Therefore, there will be no lapse in services.

vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

The traditional 1915(c) Traumatic Brain Injury and Spinal Cord Injury, DD Tiers 1, 2, 3, 4, and iBudget waivers allow individuals to live in licensed facilities. Those individuals will not be allowed to participate in the CDC+ program based on this requirement.

viii. Geographic Limitations and Comparability

A. ___X___ The State elects to provide self-directed personal assistance services on a statewide basis.

B. _____ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:_____

C. _____ The State elects to provide self-directed personal assistance services to all eligible populations.

D. ___X___ The State elects to provide self-directed personal assistance services to targeted populations. Please describe: Eligibility for the program is limited to individuals enrolled in the A/DA Waiver, DD Tiers 1, 2, 3, 4 Waiver, iBudget Waiver or TBI/SCI Waiver.

E. ___X___ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. _____ The State elects to provide self-directed personal assistance services to _____ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

C. The State assures that an evaluation will be performed of participants' need for personal assistance services for individuals who meet the following requirements:
   i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
   ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
   iii. May require self-directed personal assistance services; or
   iv. May be eligible for self-directed personal assistance services.

iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.

v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.

vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.

vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant's needs.

viii. Includes a method of notifying participants of the amount of any limit that applies to a participant's self-directed PAS and supports.

ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider's influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

Not applicable.

xi. Quality Assurance and Improvement Plan

The State's quality assurance and improvement plan is described below, including:

i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and

The state will conduct activities of discovery, remediation and quality improvement by using tools to collect data, take action and continuously improve the program. The tools developed for CDC+ fit into a complete quality management plan. These tools include: consumer satisfaction surveys, toll-free helpline, Personal Goal Setting Tool for the A/DA and TBI/SCI waivers and Person Centered Planning process (PCP) for the DD Tier 1, 2, 3, 4, and iBudget waivers and the same follow-up instrument for each group, data reports, a Quality Advisory Committee, and monitoring of consultants and consumers.

I. The Consumer Satisfaction Surveys will be distributed on a yearly basis. The surveys will be accompanied by a letter from the program director explaining its importance and that feedback is necessary for continuous program improvement. Confidentiality will be kept on the surveys, however there is an option to include the responders name and appropriate information if the responder feels necessary or would like to be contacted.

information, payment problem trouble-shooting, or making complaints. The e-mail addresses assists consumers with budget plan issues as well as timesheet and vendor invoice questions. In addition, DOEA program staff responds to online applicants who wish to apply for CDC+, checking eligibility and then responding appropriately.

Remediation: Calls and emails into the helpline and e-mail addresses will be logged, researched and responded to within 48 business hours (Monday through Friday from 8:00 A.M. until 5:00 P.M. Eastern Standard Time [EST] excluding holidays). Resolution does not guarantee that the caller is satisfied with the response of the call but was given an answer to their question or issue.

Quality Improvement: Helpline and e-mail logs will be reviewed on a quarterly basis as part of ongoing quality assurance. The logs will describe the type of caller (consumers or consultants) and how quickly the call was answered or resolved. The logs will aid the program offices in quality assurance enabling them to see what issues are facing the callers. For example, prospective consumers may call with reports of false information being distributed concerning the program. This type of information will allow the program office to provide outreach to the public, identify and refute misinformation as well as distribute correct information about the program. Consumers use the helpline and the consumer e-mail addresses to resolve payment issues, questions about budget/purchasing plans, and general program questions. Both operating agencies also have current web-sites with current information and forms for consumers. The operating agencies track consumer issues by a "Notes" section on their respective databases and record any issue regarding the consumer. That way any staff member can access a consumer file for current consumer information.

III. The Personal Goal-Setting Tool (PGS) was developed in conjunction with SCRIPPS for the A/DA and TBI/SCI waivers. The Person Centered Planning (PCP) process will provide waiver support coordinators/consultants with information gathering tools and techniques that are critical to identifying the strengths, abilities, interests and personal goals of individuals with developmental disabilities on the DD Tiers 1, 2, 3, 4, and iBudget waivers. The same follow-up instrument is used for both Tools.

Discovery: The PGS Tool for A/DA and TBI/SCI waivers and PCP process for DD Tiers 1, 2, 3, 4, and iBudget waivers allow consumers to list their needs and goals and define what services and supports will help them to satisfy their needs and reach their goals. For example a personal goal might be to spend more time with family and friends. The service they can use to reach that goal may include a certain frequency of homemaker hours once a week so the consumer can feel comfortable having visitors.

Remediation: These tools help the consumer decide what services and supports should be listed on their purchasing plan. The PGS Tool for A/DA

and TBI/SCI and PCP process for DD Tiers 1, 2, 3, 4, and iBudget waivers are implemented when the consumer begins the program and at their yearly assessment. The same follow-up instrument for both tools is completed at the semi-annual visit.

Quality Improvement: The follow-up instrument asks the consumer if their goals have been reached. Questions include: 1) Have you met Goal #1 listed on the PGS/ PCP Tool? 2) Do you want to change any of your current goals? From this point, the consumer might decide their goals have changed. The follow-up instrument will be conducted no less than once a year at the consumer's annual reassessment. The follow-up instrument also incorporates a "mini-survey" from consumers concerning health, safety, and welfare, their service needs, and their feelings regarding the program. From the follow-up instrument, the program offices can gloss pertinent consumer issues for the annual consumer survey.

IV. Consultant services for individuals with developmental disabilities will be provided by certified support coordinators trained to assume the consultant's role and responsibilities. Certified case managers and other Consumer-Directed Care Plus (CDC+) trained individuals provide consultant services for elders and adults with physical disabilities. Certified Community Support Coordinators provide consultant services for Traumatic Brain Injury or Spinal Cord Injury (TBI/SCI) Waiver consumers. These certification and training requirements will help assure effective and competent consultants and preserve waiver consumers' choice of consultant. Consultants are trained by Consumer-Directed Care Plus (CDC+) program staff in the overall philosophy of self-direction and specifically in the operations of the CDC+ program. To provide services to CDC+ consumers, consultants are required to be Medicaid waiver service providers for consultant services only. Consultants cannot serve as the consumer's representative. Consultants who are not certified case managers/support coordinators will be considered for enrollment on a case-by-case basis and the Agency for Health Care Administration (AHCA) has the final approval authority. Approval will be granted to those individuals who have a valid provider agreement with the Medicaid agency and who must meet the same training and certification provider requirements as those on the traditional 1915(c) Home and Community-Based Services (HCBS) waivers.

Discovery: Consultant monitoring will include desk reviews and individual participant interviews. Desk reviews will be conducted on a quarterly basis to a random sampling of no less than 10% of all consultants for each program population. For consultants serving five or more CDC+ consumers, the desk reviews will include monitoring the consultant file for at least five randomly selected consumers. For consultants serving less than five CDC+ consumers, two files shall be reviewed. The file must include all necessary documentation for that consumer. Documentation includes items such as: annual Medicaid eligibility

determination and a completed and signed Personal Goal-Setting (PGS) Tool for A/DA and TBI/SCI waivers or Person Centered Planning (PCP) process for DD Tiers 1, 2, 3, 4, and iBudget waivers. The consultant must have monthly contact with the consumer and visit the consumer in their home or community activity no less than once per six-month period. Monthly contact may be in the form of phone calls or in person, whichever is the preferred method of the consumer. Documentation of home visits and monthly contact must be in the consultant files for each consumer. There is a Monthly Contact Review Form that must be completed by the consultant and includes topics such as: 1) Reviewed Monthly Budget Statement with the consumer and services are purchased along

with purchasing plan. 2) Consumer has all receipts for cash purchases made in the current month. 3) Change in service needs due to change in circumstances.

Remediation: The consultant receives a copy of the consumer's Monthly Budget Net Worth Statement from APD for the DD Tiers 1, 2, 3, 4, and iBudget consumers and from DOEA for the A/DA and TBI/SCI consumers and must review that with the consumer as part of their monthly contact. If the consumer is not making purchases in accordance with his/her approved budget/purchasing plan, the consultant must complete a Corrective Action Plan (CAP) with the consumer. Consumers must sign that they understand the implications of the CAP as well following the required action. The CAP must be implemented immediately and all purchases should reflect the CAP by the next monthly consultant review. If the consumer's purchases are still outside the guidelines of CDC+ and/or the budget/ purchasing plan after 60 days, then the consumer will be disenrolled from the program and returned to his/her corresponding traditional 1915(c) HCBS waiver.

Quality Improvement: At the semi-annual home visit, the consultant must look for indicators of fraud, abuse, neglect or exploitation and must report any findings to the proper authorities within 24 hours of the visit. Failure of the consultant to perform the monitoring duties will terminate the consultant from providing services on the CDC+ program. The program offices will immediately assist the consumer in locating a new, local consultant. Each operating program office (DOEA and APD) has a contingency plan for consultant deficiencies. The state assures that all of Centers for Medicare and Medicaid Services (CMS) assurances listed in this application regarding participant safeguards, participant eligibility and budget development will be addressed in the monitoring of consultants.

V. The Quality Advisory Committee (QAC) is comprised of key program stakeholders. There will be two QACs. Each QAC will serve in an advisory capacity on behalf of DOEA and APD, respectively.

Discovery: All reporting data is shared with the QAC. Along with reviewing data, the QAC will also look at other ways to improve the program and make suggestions to the program offices. The QAC meets on a quarterly basis. The QAC may include consumers, program staff, consultants, consumer-representatives, care-givers, Area Office staff, lead agency staff, (AHCA) external reviewers (if applicable), and community advocates. APD and DOEA will recommend members to each QAC as appropriate, and AHCA will serve as the approval authority.

- APD will implement a helpline call log.
    - This aids in monitoring so the program office is made aware of what types of complaints or questions are called in to the APD.

The Outcome Measures listed below are taken from the current Personal Goal-Setting (PGS) Tool for the A/DA and TBI/SCI waivers and PCP process for the DD Tiers 1, 2, 3, 4, and iBudget waivers and follow-up instrument; there are also quarterly monitoring items:

- The PGS Tool for the A/DA and TBI/SCI waivers or PCP process for the DD Tiers 1, 2, 3, 4, and iBudget waivers must be completed before a consumer completes their first budget/purchasing plan.
    - This aids the consumer in identifying their goals and needs in order to input the services and supplies which will help them to complete their goals.
- Each consumer will need to list their personal goals and identify which services or supports will help them to reach those goals.
    - This will help the consumer to identify and achieve their goals. For example: Goal #1 might be to live in their own home and remain as independent as possible. In order to reach that goal, the consumer might need to hire someone during the week days to provide personal assistance.
- The follow-up instrument will be conducted at least every six months.
    - This will aid the consumer in determining if their goals are being met.
- The consumer will also be able to identify if they need to modify their goals at their bi-annual follow-up. All consumers must be able to request a change to their service plan based on a change in needs or health status. Service plans must be reviewed annually, or whenever necessary due to a change in a consumer's needs or health status.
    - This will allow the consumer to identify new goals or change current goals and identify the services and supports that will meet the new goals and include them on their purchasing plan, removing any services or supports that are no longer necessary.
- The consultant file must include the annual Medicaid eligibility document for each consumer. This helps to assure the state that there are not ongoing issues with consumers being ineligible for Medicaid because of a missed meeting or other situation that could have been taken care of by completing a document or attending a meeting.

- This will aid the program office in ensuring all consumers retain their Medicaid eligibility and all consultants are tracking annual Medicaid meetings for their consumers.

- Every consultant must maintain a signed consent form. The form must be either signed by the consumer or representative, if applicable. The consent form will serve as verification that the consumer is responsible for directing their own care and fully understands the program.

    - This will aid the state to ensure all consumers understand and consent to participate in this program.

The following Satisfaction Measures are taken from the Consumer Satisfaction Survey:

- The Budget/Purchasing Plan had clear instructions on how to complete.

    - The program offices need to verify information and instructions distributed to consumers are user-friendly. At least 80% of the consumers must agree that program materials are user-friendly. All results from the Satisfaction Survey will be given to the Quality Advisory Committee (QAC). The QAC will help determine the priorities for the performance indicators in which the state will need to meet. If the state is falling behind expectations on the performance indicators, the QAC will help determine how to correct or improve the processes.

- Payments for consumers' invoices and timesheets must be made in a timely manner.

    - This will inform the program offices if the subagents are performing their duties and in a timely manner. If not, the program office will need to discuss a corrective action plan with the subagents.

- Payment issues were responded to within 48 business hours.

While a response is expected within 48 business hours; (A response could include situations in which the issue is still being researched) 90% of issues should be resolved within 72 business hours.

- The consumer's net worth/monthly statement must be received every month.

    - This will aid the program office in determining if consumers are indeed receiving their statements. Statements must be received in order for the consumers to reconcile their balances monthly. Also consumers use their statements to ensure their purchases are accurately reflected.

xvi. Financial Management Services

A. __ The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. __X_ The State elects to provide financial management services through a reporting or subagent through its fiscal intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. ____The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48.)

iii. ____The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. __X__ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

1915(j) SELF-DIRECTION METHODOLOGY

DEVELOPMENTAL DISABILITIES TIERS 1, 2, 3, 4 AND IBUDGET WAIVERS

Florida's methodology for determining the consumer's budget is based on the assessment of needs and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for services listed on page 3 of Supplement 4 to Attachment 3.1-A under the 1915(c) waiver and the expected reimbursement for the cost of state plan personal care services. It is adjusted to account for the self-directed service delivery model. Based on historical utilization patterns and differences in set-up and oversight, the State will use an adjustment factor of 87.25% of the expected waiver/state plan service reimbursement to calculate the consumer's service budget for self-directed personal assistance services.

TRAUMATIC BRAIN INJURY/SPINAL CORD INJURY WAIVER

Florida's methodology for determining the consumer's budget is based on the assessment of needs and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for services listed on pages 2 and 3 of Supplement 4 to Attachment 3.1-A under the 1915(c) waiver and is adjusted to account for the self-directed service delivery model. Based on historical utilization patterns and differences in set-up and oversight, the State will use an adjustment factor of 83% and $37.00 per month of the expected waiver service reimbursement to calculate the consumer's service budget for self-directed personal assistance services.

AGED AND DISABLED ADULT WAIVER

Florida's methodology for determining the consumer's budget is based on the assessment of needs and the development of the service plan. The cost of providing the services included in the service plan is calculated based on the expected reimbursement for services listed on page 1 and 2 of Supplement 4 to Attachment 3.1-A under the 1915(c) waiver and is adjusted to account for the self-directed service delivery model. Based on historical utilization patterns and differences in set-up and oversight, the State will adjust the expected waiver service reimbursement by $37.00 per month to calculate the consumer's service budget for self-directed personal assistance services.